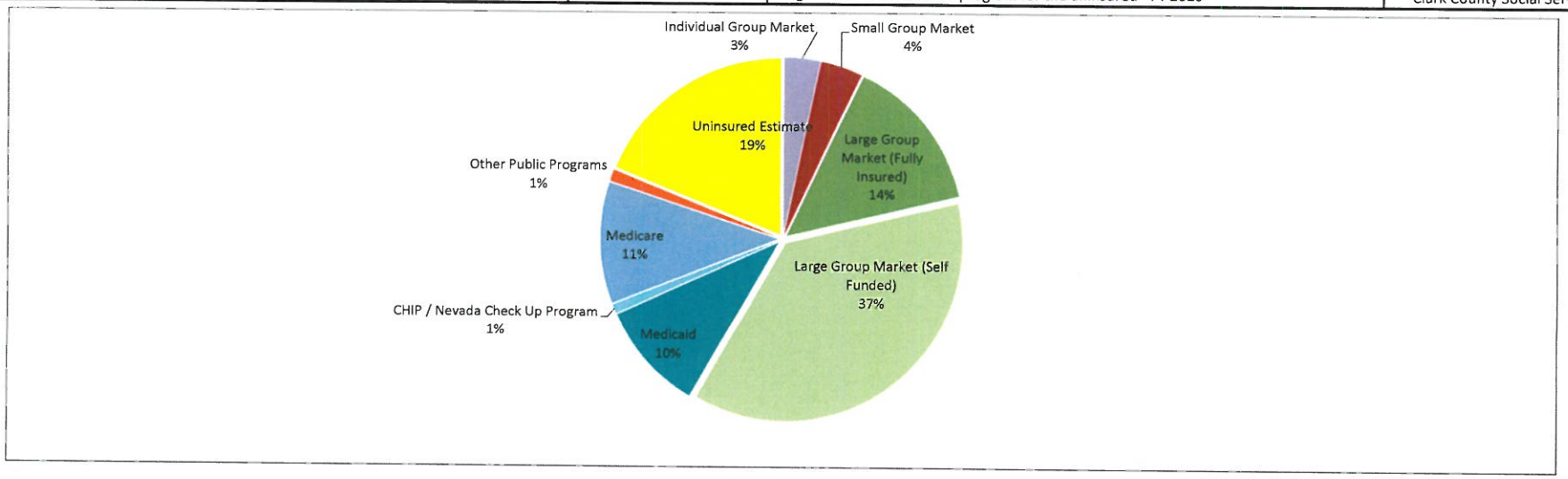
HEALTH CARE REFORM

NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES

HIGH-LEVEL OVERVIEW OF HEALTH INSURANCE COVERAGE BY SOURCE OF COVERAGE IN NEVADA

PRODUCED BY THE PUBLIC CONSULTING GROUP

Population / Coverage Category	Estimated Member Count	Member Count as a Percentage of Total State Population	Data Description	Data Source
Total Estimated Population in Nevada	2,641,410	100%	Population for calendar year 2010	NV State Demographer
Individual Group Market	87,309	3%	Member count as of 9/2010	NV DOI
Small Group Market	100,452	4%	Member count as of 9/2010	NV DOI
Large Group Market (Fully Insured)	375,358	14%	Member count as of 9/2010	NV DOI
Large Group Market (Self Funded)	976,966	37%	Estimates based on March 2009 and 2010 CPS and NV data	US Census Bureau / PCG
Medicaid	263,289	10%	Estimated 12 month average for 2010	NV DHHS
CHIP / Nevada Check Up Program	21,483	1%	Estimated 12 month average for 2010	NV DHHS
Medicare	290,555	11%	Estimates based on March 2009 and 2010 CPS	US Census Bureau
Other Public Programs	26,414	1%	Estimates based on March 2009 and 2010 CPS	US Census Bureau
Uninsured Estimate	499,584	19%	Estimate based on accessible data above and CPS	PCG estimate
Total Covered Population	2,141,826	81%	Estimate based on accessible data above	PCG estimate
County Indigent Program (subsest of uninsured)	32,855	1%	Indigent medical assistance program for the uninsured - FY 2010	Clark County Social Service



Briefing Papers

DIVISION OF HEALTH CARE FINANCING AND POLICY

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (ACA)
HEALTH CARE REFORM

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Implementation Timelines

Implementation Timeline

Print Share

The implementation timeline is an interactive tool designed to explain how and when the provisions of the health reform law will be implemented over the next several years.

You can show or hide all the changes occurring in a year by clicking on that year. Click on a provision to get more information about it. Customize the timeline by checking and unchecking specific topics.

Provisions by Year

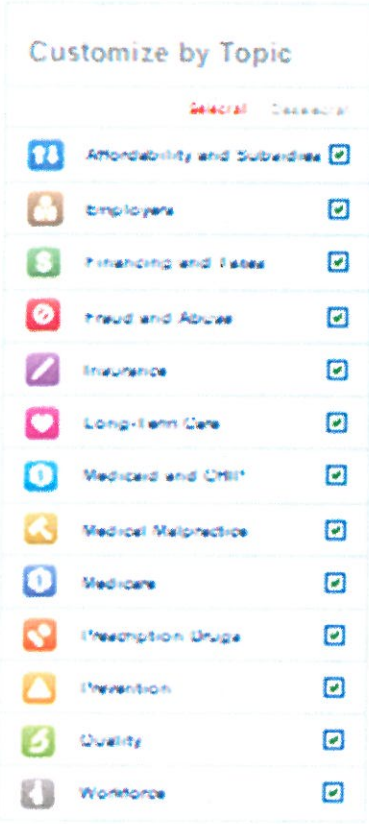
Expand all content

- 2010 (25)
- 2011 (21)
- 2012 (10)
- 2013 (13)
- 2014 (20)
- 2015 (1)
- 2016 (1)
- 2018 (1)

Customize by Topic

Select all Deselect all

- Affordability and Subsidies
- Employers
- Financing and Taxes
- Fraud and Abuse
- Insurance
- Long-Term Care
- Medicaid and CHIP
- Medical Malpractice
- Medicare
- Prescription Drugs
- Prevention
- Quality
- Workforce



Provisions by Year

Collapse all content

2010 (25)

- Review of Health Plan Premium Increases
- Changes in Medicare Provider Rates
- Medicaid and CHIP Payment Advisory Commission
- Comparative Effectiveness Research
- Prevention and Public Health Fund
- Medicare Beneficiary Drug Rebate
- Small Business Tax Credits
- Medicaid Drug Rebate
- Coordinating Care for Dual Eligibles
- Generic Biologic Drugs
- New Requirements on Non-profit Hospitals
- Medicaid Coverage for Childless Adults
- Reinsurance Program for Retiree Coverage
- Pre-existing Condition Insurance Plan
- New Prevention Council
- Consumer Website
- Tax on Indoor Tanning Services
- Expansion of Drug Discount Program
- Adult Dependent Coverage to Age 26
- Consumer Protections in Insurance
- Insurance Plan Appeals Process
- Coverage of Preventive Benefits
- Health Centers and the National Health Service Corps
- Health Care Workforce Commission
- Medicaid Community-Based Services

2011 (21)

- Minimum Medical Loss Ratio for Insurers
- Closing the Medicare Drug Coverage Gap
- Medicare Payments for Primary Care
- Medicare Prevention Benefits
- Center for Medicare and Medicaid Innovation
- Medicare Premiums for Higher-Income Beneficiaries
- Medicare Advantage Payment Changes
- Medicaid Health Homes
- Chronic Disease Prevention in Medicaid
- CLASS Program
- National Quality Strategy
- Changes to Tax-Free Savings Accounts
- Grants to Establish Wellness Programs
- Teaching Health Centers
- Medical Malpractice Grants
- Funding for Health Insurance Exchanges
- Nutritional Labeling
- Medicaid Payments for Hospital-Acquired Infections
- Graduate Medical Education
- Medicare Independent Payment Advisory Board
- Medicaid Long-Term Care Services

2012 (10)

- Accountable Care Organizations in Medicare
- Medicare Advantage Plan Payments
- Medicare Independence at Home Demonstration
- Medicare Provider Payment Changes
- Fraud and Abuse Prevention
- Annual Fees on the Pharmaceutical Industry
- Medicaid Payment Demonstration Projects
- Data Collection to Reduce Health Care Disparities
- Medicare Value-Based Purchasing
- Reduced Medicare Payments for Hospital Readmissions

2013 (13)

- State Notification Regarding Exchanges
- Closing the Medicare Drug Coverage Gap
- Medicare Bundled Payment Pilot Program
- Medicaid Coverage of Preventive Services
- Medicaid Payments for Primary Care
- Itemized Deductions for Medical Expenses
- Flexible Spending Account Limits
- Medicare Tax Increase
- Employer Retiree Coverage Subsidy
- Tax on Medical Devices
- Financial Disclosure
- CO-OP Health Insurance Plans
- Extension of CHIP

2014 (20)

- Expanded Medicaid Coverage
- Presumptive Eligibility for Medicaid
- Individual Requirement to Have Insurance
- Free Choice Vouchers
- Health Insurance Exchanges
- Health Insurance Premium and Cost Sharing Subsidies
- Guaranteed Availability of Insurance
- No Annual Limits on Coverage
- Essential Health Benefits
- Multi-State Health Plans
- Temporary Reinsurance Program for Health Plans
- Basic Health Plan
- Employer Requirements
- Medicare Advantage Plan Loss Ratios
- Wellness Programs in Insurance
- Fees on Health Insurance Sector
- Medicare Independent Payment Advisory Board Report
- Medicare Disproportionate Share Hospital Payments
- Medicaid Disproportionate Share Hospital Payments
- Medicare Payments for Hospital-Acquired Infections

2015 (1)

Increase Federal Match for CHIP

2016 (1)

Health Care Choice Compacts

2018 (1)

Tax on High-Cost Insurance

Health Insurance Exchange

Title: Available Coverage Choices for All Americans *(American Health Benefit Exchanges)*
Section: Subtitle D
State Option

Overview: Subtitle D of the Patient Protection and Affordable Care Act (ACA) establishes the American Health Benefit Exchanges, which are to be operated in every state. The Exchanges are intended to create a more organized and competitive health insurance market by offering individuals and small employers a choice of health plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers and employers better understand the health insurance options available to them. The Exchange will serve as a conduit through which individuals, and to a limited extent small employers, will be able to receive premium subsidies for the purchase of commercial insurance, as well as reduced cost sharing (e.g., deductibles, co-payments, co-insurance) for certain lower- and middle-income individuals.

The Exchange must be administered by a government agency or non-profit entity established by the State. The American Health Benefits Exchange (for individuals) and the Small Business Health Options (SHOP) Exchange (for small employers) will serve as central points of access to commercial health insurance for tens of thousands of Nevada residents and business owners.

By January 2014, individuals and small employers will be able to shop for insurance from a range of health plans offered through the Exchange. Lower- and middle-income individuals earning up to four times the Federal Poverty Level (FPL) – more than $88,000 for a family of four in calendar year 2010 – may be eligible for premium subsidies for commercial health plans. Small employers with lower-income workers that provide employer-sponsored insurance (ESI) may be eligible for premium subsidies for up to two years.

The ACA sets broad parameters for the Exchange and federal regulations will provide further guidance, however, states are allowed some flexibility in developing their own Exchange. Although much remains to be determined with regard to the set up of the Exchange, the State of Nevada will need to begin planning and establishing the infrastructure and the policies required for the successful implementation of the Exchange.

In addition to providing a brief overview, identifying targeted populations, estimating the fiscal impact, and discussing the Exchange's applicability to Nevada, the final section of this document presents important goals for Nevada's Exchange and identifies issues and opportunities that emphasize the importance of early planning and decision making. It seeks to ask key questions about the Exchange necessary to proceed with planning Nevada's eligibility

systems and its relationship to the Exchange. At the end of the paper, a series of recommendations and assumptions are presented to facilitate those efforts.

Targeted Populations: Individuals without access to employer-sponsored insurance and people who are otherwise ineligible for publicly-subsidized health coverage programs (e.g., Medicaid, CHIP), as well as small employers, may purchase insurance through the Exchange. The Exchange can limit participation to those businesses with 50 or fewer employees during the first two years of operations (i.e., 2014 and 2015), but in 2016 must expand eligibility to groups with up to 100 employees. At its discretion, larger groups may be eligible to purchase coverage through the Exchange starting in 2017.

Fiscal Impact: The State was recently awarded an Exchange planning grant of $1 million from the federal government. These funds, which must be used during the 2011 federal fiscal year (i.e., October 1, 2010 through September 30, 2011), will help Nevada assemble information, identify priorities, assess resource needs, and lay the foundation for the development of a fully-functioning Health Insurance Exchange.

In addition to the initial planning grant, the federal government has indicated that it will be releasing a second round of grants to the states in the spring of 2011 to help pay for Exchange implementation. Over the next several months, Nevada will need to establish a business plan and budget for the establishment of an Exchange.

Per the ACA, the Exchange must be financially self-sustaining by 2015, one year after it becomes operational. Therefore, a financing mechanism will need to be established to support administration of the Exchange.

At this time, the fiscal impact of the Exchange on the State is unknown.

Applicability to Nevada: In order to meet the January 2014 effective date for the expansion of Medicaid eligibility and the availability of subsidized health insurance through the Exchange, Nevada is in the process of developing a comprehensive plan that seeks to integrate the Exchange into existing publicly-subsidized health coverage programs and to complement commercial (primarily employer-sponsored) health insurance, through which most State residents receive their health coverage. We have identified three primary goals for the establishment of an Exchange in Nevada: (1) expand access to health coverage for residents of the State who are uninsured and lack access to affordable coverage; (2) leverage existing resources in the public and private sector to achieve administrative efficiencies; and (3)

minimize, to the greatest extent possible, unintended disruption to the commercial health insurance markets.

The initial work will focus primarily on developing estimates of the potential populations to be served by the Exchange, continuing the work that we have already started to establish a streamlined eligibility process to serve all applicants for all medical assistance programs, preparing detailed information on the commercial health insurance markets, defining a governance structure and administrator for the Exchange, cataloguing existing resources that may be used to support an Exchange, and identifying services that will need to be developed or contracted to operate the Exchange.

Basic Role of the Exchange

The Patient Protection and Affordable Care Act (ACA) broadly identified goals for Health Insurance Exchanges. Exchange design is critical to assuring these goals are met. Those goals are as follows:

- Slowing medical inflation;
- Ending exclusionary practices such as denial of coverage for pre-existing conditions;
- Facilitating plan selection and enrollment;
- Determining and providing subsidies to low-income residents;
- Ensuring meaningful health coverage; and
- Promoting transparency and accountability with health plans and providers.

Bending the Cost Curve

Exchange policies related to plan design can facilitate consumer value decisions, including selection of lower cost plans, which in turn will increase price competition. Increased competition among plans and the concentration of covered lives in the Exchange could also increase provider competition on cost and quality. While standardizing benefits will help consumers with price comparisons, it will have to be balanced with creative market offerings and choice.

Insurance and Medicaid agencies do not have all the expertise needed to manage the Exchange and the dynamics of the market place. This suggests that a new state governance structure is necessary to oversee the Exchange. This will be discussed in more detail later in this document.

Spreading Risk

Currently, the health insurance market focuses on avoiding or segregating adverse risk, which leads to processes like medical underwriting and excluding coverage of pre-existing conditions. Spreading risk helps stabilize the cost of coverage and can help make coverage available at a reasonable cost when people are sick.

The concentration of covered lives is essential in spreading risk across a large population. The National Governor's Association recently estimated that states may be overseeing health insurance coverage for 25% to 50% of their state's residents through the Exchange. Utah officials reported that they anticipate 80% of their residents will enroll in coverage through their Exchange. Exchange policies on risk selection, including community rating requirements in the ACA, will be required to prevent segregating behaviors among health plans.

To create additional opportunities for risk spreading and avoiding risk segregation, consideration should be given to increasing the numbers of lives flowing through the Exchange. By January 1, 2014, each state must have an operational Exchange where residents may purchase insurance coverage from qualified health plans. States must also establish a Small Business Health Options Program (SHOP Exchange). This can be a separate Exchange or be a part of the main Exchange. In considering the advantage of "large numbers" in risk spreading, it may be necessary to include the SHOP Exchange in the overall statewide Exchange.

There is also a policy question as to whether a state creates the Exchange as an exclusive marketplace versus allowing coverage to be purchased outside of the Exchange. The ACA requires each carrier to pool risk for all non-grandfathered plans in the individual and small group markets. This provides some protection against risk selection outside of the Exchange. However, there is still the potential for risk selection to occur. It will be important to monitor these markets to prevent risk selection.

Facilitating Plan Enrollment

Making plan selection as easy and transparent as possible for small employers and individuals subject to the mandates in the ACA will be essential. Accurate and reliable information on benefits, premiums, subsidies and options will be a key Exchange function, as well as enrolling individuals in the correct plan after they make a plan choice.

Reducing the "churn" between Medicaid and qualified health plans in the Exchange will reduce State and health plan administrative costs and assure better continuity of care. To deal with this, some states are considering requiring Medicaid plans to also participate as a qualified

health plan in the Exchange. Currently, of the two contracted Medicaid HMOs in Nevada, only one offers commercial coverage as well as a Medicaid line of business.

Determining and Providing Health Insurance Subsidies

Calculating subsidies and assuring those subsidies are provided to the enrollee's chosen health plan will be an administrative challenge. To administer subsidies, the Exchange would need to gather and evaluate information relevant to an individual's ability to pay for insurance. Centralizing administration of subsidies and payments to insurers in the Exchange may provide an efficient means of managing these payments. Procedures and technology for enabling these functions will take time to design and implement.

Ensuring Meaningful Coverage

Health coverage should pay medical bills when someone is sick and accesses medical services. This can be promoted by requiring health plans to provide a minimum standard of coverage to qualify as an Exchange plan. Qualified health plans must offer "essential health benefits"[1] commonly found in standard employer health policies. Benefit plans must fall into five categories based on actuarial value: Platinum; Gold; Silver; Bronze; and High Deductible Health Plans (HDHPs).[2] Plans must also meet requirements for provider choice, accreditation and other criteria. Enforcement of these plan requirements will be the responsibility of the Exchange in coordination with the Insurance Division.

There will be pressure to increase the level of benefits required of plans. There will also be pressure on qualified plans to meet administrative or quality requirements beyond the minimum required under the ACA. More benefits and more administrative requirements will obviously lead to greater cost. In addition, states may require that plans offer benefits in addition to the minimum essential health benefits, but the State must make payments to individuals eligible for subsidies to offset the cost of these additional benefits.

Standard benefit plans will facilitate risk spreading in the Exchange as standard benefit plan designs will discourage consumers from gravitating to a particular plan design based solely on

[1] The Secretary of Health and Human Services is responsible for determining what constitutes "essential health benefits."

[2] Catastrophic plans may only be purchased by individuals' 30-years old or younger, or by people who are exempt from the individual mandate based on affordability or hardship. An employer purchasing coverage through the Exchange will not be allowed to offer his/her employees an HDHP.

medical needs. Experience with Medicare Part D suggests this can be an issue. Patients with high cost prescription medications would "plan shop" to find the best deal for their particular medical condition causing them to aggregate in a particular plan that offered that drug. However, standard benefit design will have to be balanced with creative market offerings to assure that consumers have a choice of products.

Promoting Transparency and Accountability

Transparent information for consumers about plan provisions, such as premiums, point-of-service cost sharing, and covered benefits, is essential. Additionally, comparative information on plan performance related to consumer satisfaction, provider choice, managing disease and keeping administrative costs low will also be important for the Exchange to provide consumers. Transparency and disclosure of data will also be necessary to monitor regulatory compliance by plans, as well as assuring plans comply with rules to promote risk spreading.

Nevada's Proposed Eligibility Engine

The Division of Welfare and Supportive Services (DWSS) is currently working with the Public Consulting Group (PCG) on a feasibility study of a proposed "Eligibility Engine." The Engine is currently envisioned to reside in conjunction with, but separate from, the electronic portal through which residents will access the Individual Insurance Exchange. Eligibility determinations, based upon adjusted gross income levels, will direct residents seeking insurance coverage to:

- Unsubsidized plan options (incomes above 400% of the Federal Poverty Level (FPL))
- Subsidized plan options if income is below 400% of FPL.
- Medicaid coverage if income is below 133% of FPL (plus 5% income disregard), or SSI.
- CHIP eligible children below 200% of FPL.

Additionally, it will:

- Calculate premium subsidies and credits available to individuals eligible for subsidized Exchange coverage.
- Provide an indication of possible eligibility for state administered public assistance programs and information on how to apply for these programs.

The design proposal is predicated on a number of key assumptions related to key policy considerations. These include:

- Nevada has not yet determined if the State will operate a Basic Health Program for individuals below 200% of the FPL (Section 1331 of the ACA). Consideration will be made for the possibility of future operation of a Basic Health Program.
- Individual Exchange will be separate from the SHOP Exchange for the purpose of eligibility determination. Presumptive Eligibility options, other than what is currently offered, will not be implemented. However, starting January 1, 2014, hospitals may separately apply to CMS to do presumptive eligibility determinations irrespective of whether the State has exercised that option in their Medicaid state plan.

For planning purposes, the relationship between the Eligibility Engine and the Exchange is being defined as follows:

- The Engine is considered within the domain of responsibility of DWSS, until decisions are made otherwise to move it to another agency or under the Exchange authority.
- The Engine will only determine eligibility for the Individual Exchange and not the SHOP Exchange. Additionally, an interface between the SHOP Exchange and the Engine is not envisioned at this time. This assumption needs to be revisited in light of the fact that concentrating large numbers of enrollees in the Exchange is vital for risk spreading.
- The Engine will calculate subsidies and credits.

Key Decisions for the Exchange

How will the Exchange be Structured?

For planning purposes, it is assumed Nevada will operate its own Exchange. Consumers and employers may feel a greater sense of ownership if the Exchange represents their interests in their own State. Local accountability and oversight would be improved if the Exchange was established at a State level. Finally, negotiations with health plans may also be more effective if conducted on a local level.

Interstate exchanges will be allowed with approval of the Secretary. The ACA also requires the federal Office of Personnel Management to establish at least two multi-state qualified health plans that will operate in exchanges in each state.

Combining the SHOP Exchange as a part of the larger Exchange must be considered for risk spreading. Additionally, offering employers and individuals similar products could reduce the "churn" affect on enrollment.

Recommendation: Establish a state-wide exchange combining the SHOP Exchange and Individual Exchange only for the purposes of risk pooling, not for eligibility purposes. Future consideration may be given to participate in regional or multi-state exchanges once the rules for multi-state compacts are promulgated.

How Should the Exchange be Governed?

The Secretary of Health and Human Services must issue regulations governing the establishment and operation of Exchanges "as soon as practicable." States will be evaluated by the Secretary by January 1, 2013 to determine if they have taken adequate steps necessary to establish an Exchange that will meet federal requirements. If a state is deemed not ready, the Secretary will establish an Exchange within the State.

Key policy decisions will need to be made related to rating and plan requirements by the State many months in advance of the January 1, 2013 readiness date to allow insurance carriers sufficient time to evaluate their interest in participating in the Exchange.

To accomplish this in the short timeframe available, Nevada must establish an Exchange with the ability to:

- Establish policies and regulations;
- Assure compliance with federal and State laws and regulations;
- Facilitate the purchase and sale of qualified health plans; and
- Oversee and administer all of the functions fundamental to achieving the goals of the Exchange.

The most important role of the Exchange will be to act as a health care facilitator, or perhaps as a selective contractor, for a large portion of Nevada's residents and small businesses. While the State Medicaid agency and the Public Employee Benefit Plan function in this capacity today, these state agencies may not have breadth and depth of experience to deal with a much larger commercial health insurance market that the Exchange will represent.

The Exchange should be established in State law. To assure it can act in time for successful implementation, the Exchange will need an appropriate level of authority to perform its functions across multiple agencies, including Medicaid/CHIP, the Public Employees Benefit Plan (PEBP) and the Insurance Division.

Under the ACA, the Exchange must be a State agency or non-profit entity established by the State. Functions of the Exchange may be subcontracted to an "eligible entity." An eligible

entity may be the State Medicaid agency or other entity incorporated in Nevada, not affiliated with the insurance industry, but with experience in the small group and individual insurance markets.

Some possible advantages to having the Exchange within a State agency include having a direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as Medicaid and the Division of Insurance . Some possible disadvantages include the risk of the Exchange's decision-making and operations being politicized and the possible difficulty for the Exchange to be nimble in hiring and contracting practices, given most States' personnel and procurement rules. The Exchange could also be located at an independent public agency, or a quasi-governmental agency, with an appointed board or commission responsible for decision-making and day-to-day operations. Some possible advantages to establishing the Exchange as an independent public agency, or a quasi-governmental agency, include possible exemption from State personnel and procurement laws and more independence from existing State agencies, which could result in less of a possibility of the Exchange being politicized.

The Exchange's enabling legislation would specify how the Board members would be appointed, including its size, composition and terms. The Board would also select the Exchange's Executive Director. Some possible disadvantages include the possible difficulty for the Exchange to coordinate health care purchasing strategies and initiatives with key State agencies, such as Medicaid and the Division of Insurance and their employees because the Exchange would not be located at a State agency (unless those decisions are subject to the approval of a State official, such as the Commissioner of Insurance or the Governor). The Exchange also could be established by creating a non-profit entity. This means that most likely it would not be directly accountable to State government or subject to State government oversight nor would it most likely be subject to State personnel and procurement laws. Some possible advantages of establishing the Exchange as a non-profit include flexibility in decision making and less of a chance for those decisions being politicized and some possible disadvantages include isolation from State policymakers and key State agency staff and the potential for decreased public accountability. In addition, States can establish an Exchange using a combination of the options described above.

Federal guidance will ultimately define what the role of the State may be to operate the Exchange. Nonetheless, several organizational models should be considered for the Exchange. The Exchange could either be established as: a State agency; a quasi-governmental entity; or an independent non-profit entity established by the State. In each case, this entity would need to have authority to establish regulations to carry out its mission.

It is important for the Exchange to have broad regulatory authority across multiple state health programs as well as the insurance industry. Governance of the Exchange needs to include the Insurance Division, Medicaid/CHIP, and the Public Employees Benefit Plan. Future consideration should also be given to include the Health Division as a part of the governance structure for the Exchange in order to facilitate its public health mission through data sharing and policy development.

While the actual structure of the Exchange is yet to be determined, it must have authority to facilitate the purchase and sale of qualified health plans. If the decision is to not establish a separate Exchange with authority over other agencies, there will be at a minimum the need for significant coordination and cooperation between the Exchange, the Insurance Division, Medicaid and PEBP.

Recommendation: Establish a governance structure for the Exchange to include the Insurance Division, Medicaid/CHIP and PEBP.

How Should the Eligibility Engine be Governed?

With the creation of the Eligibility Engine, a multi-department governance structure will need to be developed in order to provide the framework for making IT decisions and to ensure that IT organizational resources are targeted to deliver maximum business value. The IT Governance process should answer the following questions:

- How will executive direction for IT be established?
- How will standards, policies and procedures be established and enforced?
- How will decisions be made regarding department-specific and enterprise-wide initiatives (e.g., business applications)?
- How will IT initiatives be prioritized? How will IT initiatives be funded?
- How will projects be governed? Who will be responsible for projects?

Recommendation: Creating a governance structure will provide a guide as to how individuals and groups will collaborate to manage technology and help to define the basis for interaction between functions, roles, programs and people as they relate to the technology that is necessary to support the implementation of Health Care Reform.

Who Should Have Access to the Exchange?

The Exchange could be the exclusive market for small employers and individuals to obtain health insurance. An alternative is to allow markets to operate for either employers, individuals or both. The existence of alternative markets creates the potential for risk segregation. This risk will be reduced with the reinsurance and risk adjustment provisions of the ACA as well as the requirement for non-grandfathered plans to follow the same rating rules. This issue could also be addressed through State regulation of plans sold inside and outside of the Exchange.

Recommendation: Allow alternative markets to exist assuming they follow the rules established for qualified health plans in the Exchange. An analysis of the impact of alternative markets on risk selection to the Exchange may be needed to determine whether alternative markets should continue.

Fiscal Impact

Division of Health Care Financing and Policy

Key Issues Summary

Budget Reductions

	SFY 11 - 12			SFY 12 - 13		
	General Fund	Other Funds	Total	General Fund	Other Funds	Total
BA 3178 M160 - 26Th Special Session Reductions	(91,711)	(199,805)	(291,516)	(89,941)	(213,504)	(303,445)
BA 3243 M160 - 26Th Special Session Reductions	(7,721,168)	(9,466,595)	(17,187,763)	(7,566,867)	(10,315,706)	(17,882,573)
SFY 12 - 13 Budget Reductions	(65,211,545)	(15,939,137)	(81,150,682)	(58,338,418)	(16,932,205)	(75,270,623)
Total	**(73,024,424)**	**(25,605,537)**	**(98,629,961)**	**(65,995,226)**	**(27,461,415)**	**(93,456,641)**

Caseload and Inflation

	SFY 11 - 12			SFY 12 - 13		
	General Fund	Other Funds	Total	General Fund	Other Funds	Total
BA 3158 M101 - Agency Specific Inflation	419,350	977,053	1,396,403	654,838	1,662,491	2,317,329
BA 3158 M200 - Demographic/Caseload Inflation	1,021,720	2,090,023	3,111,743	1,364,082	3,055,865	4,419,947
BA 3178 M101 - Agency Specific Inflation	255,679	557,033	812,712	366,855	870,846	1,237,701
BA 3178 M200 - Demographic/Caseload Inflation	260,869	503,036	763,905	655,499	1,522,906	2,178,405
BA 3243 M101 - Agency Specific Inflation	3,206,657	4,837,166	8,043,823	5,319,467	8,674,437	13,993,904
BA 3243 M200 - Demographic/Caseload Inflation	44,254,143	53,516,864	97,771,007	66,758,107	90,570,102	157,328,209
BA 3243 M201 - Demographic/Caseload Inflation	58,220,218	75,162,275	133,382,493	54,015,922	79,366,571	133,382,493
Total	**107,638,636**	**137,643,450**	**245,282,086**	**129,134,770**	**185,723,218**	**314,857,988**

Health Care Reform

	SFY 11 - 12				SFY 12 - 13			
Decision Unit	General Fund	Other Funds	Total	# of FTE	General Fund	Other Funds	Total	# of FTE
BA 3158 M501 - Provider Rate Increase	-	-	-	-			-	-
BA 3158 M502 - Class Survey	25,000	25,000	50,000		11,117	11,116	22,233	
BA 3158 M503 - Provider Support/Hearings	50,981	54,284	105,265	2.00	62,129	66,681	128,810	2.00
BA 3158 M505 - Benefit Coverage Staff	51,878	55,111	106,989	2.00	63,005	67,562	130,567	2.00
BA 3158 E402 - Health Insurance Exchange	-	1,008,606	1,008,606		-	13,389,143	13,389,143	
BA 3178 E681 - Drug Rebate Impact	45,932	100,068	146,000		45,721	108,532	154,253	
BA 3243 M501 - Physicians Rate Increase	-	-	-		-	4,539,278	4,539,278	
BA 3243 E680 - Program Integrity Recoveries	(3,998,146)	(5,679,505)	(9,677,651)		(3,902,262)	(6,127,086)	(10,029,348)	
BA 3243 E681 - Drug Rebate Impact	(842,430)	(1,031,720)	(1,874,150)		(806,529)	(1,098,359)	(1,904,888)	
Total	**(4,666,785)**	**(5,468,156)**	**(10,134,941)**	**4.00**	**(4,526,819)**	**10,956,867**	**6,430,048**	**4.00**

Loss of ARRA FMAP Enhancement

	SFY 11 - 12			SFY 12 - 13		
	General Fund	Other Funds	Total	General Fund	Other Funds	Total
BA 3243 M170	101,567,051	(101,567,051)	0	71,720,929	(71,720,929)	0
BA 3243 M171	(5,567,529)	5,567,529	0	(5,540,536)	5,540,536	0
Total	**95,999,522**	**(95,999,522)**	**-**	**66,180,393**	**(66,180,393)**	**-**

TIR's

	SFY 11 - 12				SFY 12 - 13			
Decision Unit	General Fund	Other Funds	Total	# of FTE	General Fund	Other Funds	Total	# of FTE
BA 3158 E410 - HIT Grant	7,563	38,430,504	38,438,067	1.00	15,144	38,087,444	38,102,588	2.00
BA 3158 E570 - ICD-10 Implementation	384,256	3,458,303	3,842,559	-	647,608	5,828,475	6,476,083	-
Total	**391,819**	**41,888,807**	**42,280,626**	**1.00**	**662,752**	**43,915,919**	**44,578,671**	**2.00**

Welfare and Supportive Services Program Initiatives

- **E-400 Health Care Reform -- Eligibility Engine**
  - Determines Individual Eligibility for Subsidized Health Care
  - Integrates Health Insurance Exchange (HIX) with Medicaid and Other Public Assistance Programs -- No Wrong Door
  - Scheduled Implementation -- January 1, 2014
  - Projected Full Cost of Implementation -- $23.4 Million
  - Requested Funding for SFY 12 & 13
    - $494,838 General Funds
    - $14,397,749 Federal Funds
    - 13 FTE's

FAQs

HEALTH CARE REFORM FREQUENTLY ASKED QUESTIONS

1. **Health care reform will have a significant impact on the current insurance market. What are some of the major changes Nevadans can expect?**

Answer:

- Beginning on July 1, 2010, the Pre-Existing Insurance Program began. This program is funded and operated by the federal government for states such as Nevada that chose not to establish a high risk pool of their own. To qualify for the pre-existing condition insurance plan, individuals must be uninsured for at least six months and have been turned down for coverage by a private insurer because of a pre-existing medical problem. This program provides immediate coverage of pre-existing conditions at premiums that are capped at the average cost of private coverage in each state's individual market. Beginning August 1, 2010, applications can be submitted online at www.pcip.gov.
- The health care reform law requires that insurers and employers that provide dependent coverage must offer coverage for adult children until their 26th birthday. This requirement becomes effective for "plan years" beginning on or after September 23, 2010.
- Eliminates lifetime limits on insurance coverage for health plan years beginning on or after September 23, 2010.
- Improves access to preventive care by eliminating any cost-sharing for preventive services covered under insurance contracts. This requirement goes into effect for health plan years beginning on or after September 23, 2010.
- Encourages employers to offer coverage by creating small business tax credits worth up to 35% of the employer's contribution to the employees' health insurance. Effective January 1, 2010.
- Requires that at least 85% of all premium dollars collected by insurance companies for large employer plans and 80% for individual and small employer plans must be spent on health care services and health care quality improvement. Insurance companies that don't meet these goals must provide rebates to consumers beginning January 1, 2011.

2. **How will health care reform help seniors with prescription drug costs?**

Answer:

- Seniors who reach the gap in prescription drug coverage known as the "doughnut hole" will receive a $250 rebate beginning June 2010.
- Beginning in 2011, seniors in the "doughnut hole" coverage gap will receive a 50% discount on prescription drugs.
- The "doughnut hole" gap will be phased out until it is eliminated in 2020.

3. **What are some of the impacts on the Nevada Medicaid Program (health care for families/individuals with low incomes)?**

Answer:

- Beginning in 2014, expands Medicaid eligibility to everyone under 133% of the federal poverty level (approximately $14,000 for an individual and $29,000 for a family of four). This includes Medicaid coverage for single, childless adults who previously were not eligible for Medicaid. States will receive 100% federal funding for the first three years to support this expanded coverage, phasing to 90% federal funding in later years.
- Restructures how eligibility is determined, requiring the use of modified adjusted gross income (MAGI) from an applicant's income tax return.
- Freezes current eligibility rules until December 31, 2013 for adults and September 30, 2019 for children.
- Increases rates paid by Medicaid for primary care services to 100% of the Medicare rate for 2013 and 2014. The increase is fully funded by the federal government.

4. **What is the estimated fiscal impact on the State of Nevada to implement the health care reform legislation?**

Answer:

- Nevada DHHS has estimated Health Care Reform will cost Nevada taxpayers about $574 million in additional General Fund dollars between now and 2019.
- Added costs fall primarily into five areas:
    1. Primary care physician rate increases to 100% of the Medicare rate (Nevada currently pays less than the Medicare rate.)
    2. New eligibles being added (such as single, childless adults).
    3. The insurance mandate provisions of the health care reform legislation will drive people who are currently eligible for Medicaid, but not enrolled, to apply for and receive Medicaid coverage.
    4. Automated systems overhauls and replacements.
    5. Added administrative costs for increased enrollees.
- Enhanced Federal funding is available for some costs, but phases out over time.

5. **How will people be able to find the most affordable health insurance?**

Answer:

- www.HealthCare.gov launched on July 1, 2010. This web portal helps consumers determine which private insurance plans and public programs are available to them in their state.

- Beginning in 2014, an "Exchange" will be established in each state to help consumers compare plans that are certified to have met benchmarks for quality and affordability. The Exchanges will also administer the new health insurance subsidies and facilitate enrollment in private health insurance, Medicaid, and the Children's Health Insurance Program (CHIP).